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Montana Morbidity Report

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VOL. 16 NO. 1 January 1992

Montana State Department of Health and Environmental Sciences

MONTANA GONORRHEA MORBIDITY DECLINES

Year 2,000 National Health Objectives for gonorrhea is to reduce the incidence to no more than 225 cases per 100,000 people. The incidence of gonorrhea in Montana has long been below national levels and continues to decline each year since 1975 when 2,082 cases were reported. The incidence of gonorrhea within the state during 1991 fell well below the target objective of the Montana STD Program of 20 cases per 100,000 people. There were 122 cases reported to the STD Program during the year, for a rate of 15 cases per 100,000 people. Although nationally, gonorrhea rates during 1991 declined from the rates reported during 1990 by 12.5 percent, (as reported in MMWR) the decline in gonorrhea cases reported to the STD Program in Montana indicates a dramatic 94 percent decline during the same time period. The graph illustrates the decrease in gonorrhea morbidity in Montana between 1986 and 1991.

While the positivity rate declined during 1991, the numbers of screening cultures for the identification of Neisseria gonorrhoeae actually increased somewhat during the year. There were 17,686 cultures performed during 1991. Five cases of penicillin resistant gonorrhea were identified by culture. It is apparent that some gonorrhea continues to be imported to Montana as 27 percent of those patients interviewed identified at least one out of state contact.

INDEX

MONTANA GONORRHEA MORBIDITY	1
MPHA ANNUAL MEETING	2
ENTEROHEMORRHAGIC E. COLI	3
HIV COURSE DATE CHANGE	3
NEW MONTANA AIDS LOGO	3
AIDS/STD BRIEF	3
TOPICAL INDEX: MONTANA MORBIDITY	4
MONTANA MORBIDITY	5
QUESTIONS ABOUT CANCER?	6

When looking at the statistics of our surrounding states, both North Dakota and Wyoming also experienced decreases in gonorrhea morbidity during the last year. The decrease observed in North Dakota was 33 percent and in Wyoming the decrease was 56 percent. However, both South Dakota and Idaho morbidity increased slightly from the previous year. The decrease in morbidity was examined in terms of type of provider (public, private, military and IHS) and while all providers experienced large decreases, the percent decrease reported by IHS was the highest. Examining morbidity by the Governor's five Health Planning Regions, all regions with the exception of Region II experienced a decline in gonorrhea morbidity. Region II morbidity for the year increased by 85 percent.

PLEASE RETURN

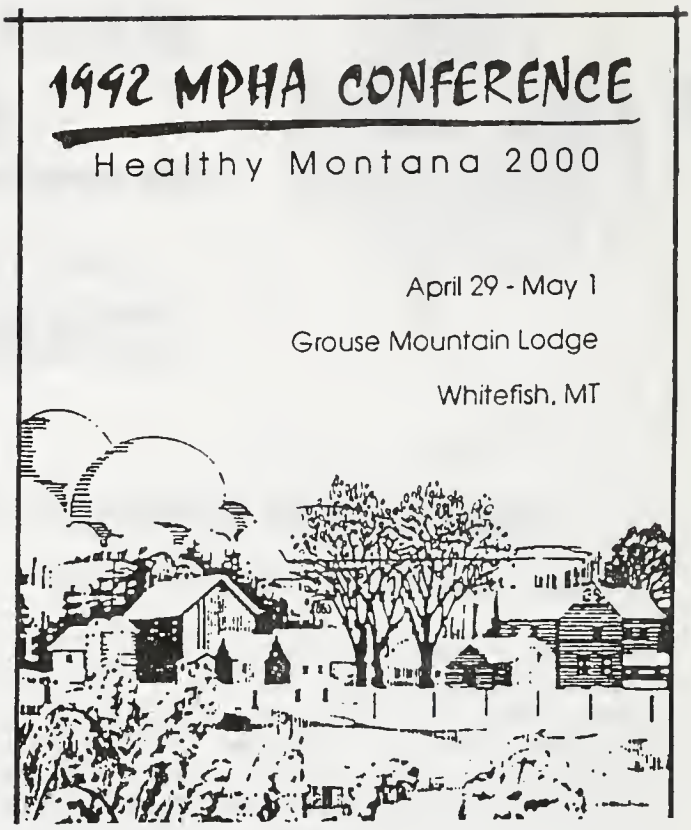
1992 MPHA ANNUAL CONFERENCE ANNOUNCED
HEALTHY MONTANA 2000

The annual meeting of the Montana Public Health Association is scheduled for April 29 - May 1, 1992, at the Grouse Mountain Lodge in Whitefish, Montana.

This year's conference will take a unique focus. For the first time, participants will have the opportunity to contribute to a comprehensive public health plan for Montana's public health network. Through a separate "planning track" participants will begin a dialogue with peers and policymakers about the impact on Montana of creating basic public health standards. As in the past, concurrent workshops will be offered which address the interests of public health nurses, school nurses, nutritionists and dietitians, and environmental health workers.

William Dyal, Director, Public Health Practice Program Office in the Centers for Disease Control, Atlanta, and Roxie Schalliol, Director of Local Health and Community Services, Washington State Department of health, will facilitate the planning sessions. Working sessions in the planning track will continue throughout the entire duration of the conference. Participants who register for the planning component are asked to make a commitment to attend all the sessions. Time will be provided for other conference participants to caucus and discuss their ideas about the development of a state public health plan.

Input from all public health constituents will be vital to this process. The diversity of viewpoints brought by a county commissioner, community health nurse, consumer, physician, family planning specialist, health educator, health officer or nutritionist will combine in a strong, unified, voice to articulate a common agenda for Montana's public health future and Healthy Montana 2000.



For more information:
Office of Continuing Education for the Health Professional
318 Montana Hall, Montana State University
Bozeman, Montana 59717
(406) 994-4930

Registration for the conference is $60. Registrations received after April 15th will be $70. A limited number of scholarships will be available for public health personnel to attend this conference. Special conference rates are available at Grouse Mountain Lodge for MPHA conference participants. For room reservations at Grouse Mountain call 1-800-321-8822. For more information about the conference, contact Montana State University, Office of Continuing Education for the Health Professional, 318 Montana Hall, Bozeman, MT 59717 (406) 994-4930.

ENTEROHEMORRHAGIC E. COLI 0157:H7

The Montana Department of Health and Environmental Sciences was recently notified of a case of E. coli 0157:H7 infection in a 15 month old girl in Great Falls. The patient presented with hemolytic uremic syndrome (HUS), and was culture confirmed for E. coli 0157:H7. Numerous additional cases have also been reported throughout Montana in recent months. While large, common source outbreaks of hemorrhagic colitis due to E. coli 0157:H7 are known to occur, the Montana cases have been sporadic and isolated.

E. coli 0157:H7 is a form of enterohemorrhagic E.coli (EHEC) which can cause diarrhea and lower intestinal bleeding in infected animals. Humans and cattle act as the primary hosts for the EHEC. The organisms are transmitted by ingestion of contaminated foods such as poorly cooked beef (especially hamburger) and unpasteurized milk.

Health care providers are alerted to the presence of diarrheal illnesses due to E. coli 0157:H7. EHEC in some patients can lead to serious and life-threatening complications.

HIV COUNSELING TECHNIQUES COURSE DATE CHANGE

The HIV Counseling Techniques Course scheduled for Bozeman during the last week of April has been changed. The course will be held in Great Falls on March 9-10, 1992. For more information, call the AIDS Program at 444-3565.

NEW MONTANA AIDS LOGO

The Montana AIDS Program has developed a new **Montana Responds to AIDS** logo, using the outline of Montana and the **America Responds to Aids** motif. This logo, shown above, will appear on future AIDS Program brochures and posters.

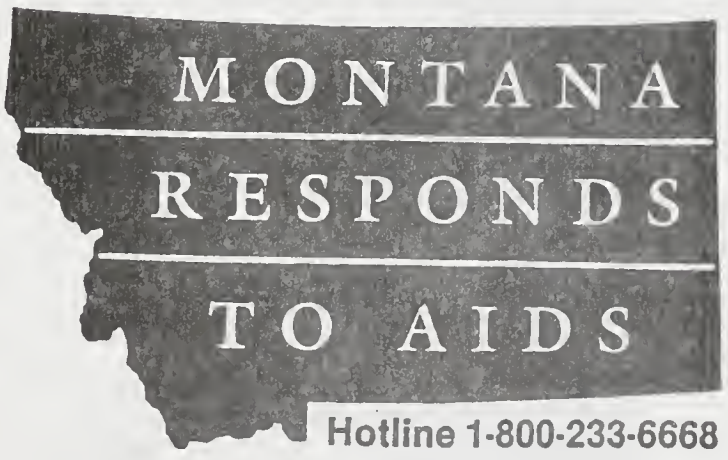
AIDS/STD BRIEFS

- The Montana Public Health Laboratory reports that 187 (7.8%) of 2,397 samples collected for chlamydia were positive for the month of January (1992). Genital chlamydia infection continues to be the most prevalent sexually-transmitted disease reported in Montana.

- Over 780 Montanan health care providers, including chemical dependency counselors, nurses and hospital volunteers, were educated on HIV/AIDS during 1991 through the Department's AIDS/STD Program.

- Changes in the Americans with Disabilities Act (ADA) will be implemented on July 26, 1992. Accordingly, employers having 25 or more workers may not discriminate against individuals with a disability in hiring or promotion. The ADA protects those that are perceived as having HIV, are HIV infected, or are living with AIDS.

- The World Health Organization (WHO) predicts that the world's AIDS cases will increase from 1.5 million in 1991 to 12-18 million by the year 2000, and that cases of HIV infection will triple to 30-40 million by the year 2000.



MONTANA MORBIDITY REPORT
TOPICAL INDEX BY MONTH
Volume 15, 1991

CANCER

Cancer treatment information for physicians ..... October

CHLAMYDIA

Chlamydia screening ..... June

CHOLERA

News on cholera ..... April
South America, travelers advisory ..... July

DIABETES

The Highs and Lows of Diabetes - seminar ..... March

DRUGS

Streptomycin and PASA unavailable .....September
New drugs added to ADRP .....November

EPIDEMIOLOGY

Chronic Disease Epidemiology Workshop offered ... January
New State Epidemiologist announced ..... February
Public Health Interviewing Course announced ..... March
Assessment guide for local Health Departments ... April
International travellers' hotline ..... April
PHS Bureau phone list update ..... April
CDC voice information system ..... June
Newsletter mail list renewal notice ..... July
Bug identified in Epi-Info software ..... July
Operation Desert Storm diseases ..... July
1991 "Red Book" available .....September

GASTROENTERITIS

Foodborne outbreak, Gallatin County ..... July
Managing diarrhea .....December

HAEMOPHILUS INFLUENZA TYPE B

Invasive HIB disease ..... April

HEPATITIS

Viral hepatitis reporting ..... May
Perinatal Hep B prevention program underway in MT June

HIV/AIDS

AIDS Funding ..... January
Staff & position changes in AIDS/STD Program .... February
AIDS Hotline Update ..... February
Ryan White-Title II funds awarded ..... March
Montana AIDS Resource Directory ..... March
New AIDS case report form ..... April
HIV & health workers: new guidelines announced .. June
AIDS planning grant ..... June
STD Interviewing Technique course announced .... June
Informed consent procedures ..... June
HIV risk assessment ..... July
H.U.D. funds available for persons with AIDS ..... July
Mandated health worker HIV tests defeated ..... October
HIV counseling and testing, Montana, 1989-90 .... October
HIV Title II informational hearing ..... November
Changes proposed in AIDS case definition ..... November
New HIV laboratory slip developed ..... December
False positive HIV tests reported ..... December

IMMUNIZATION

Certificate of Immunization - supply orders ..... March
Montana Immunization Record card available ..... July
Immunization contraindications; misconceptions ... August
Missed opportunities .....November

INFLUENZA

Influenza, Montana, 1990-91 season ..... April
Influenza recommendations, 1991-92 season ..... August
Vaccine update .....September
Influenza season approaches ..... October
Influenza Update, Montana, 1991-1992 ..... November

LEAD POISONING

Lead poisoning alert ..... September
Childhood lead poisoning ..... October

LEGIONELLOSIS

Hot tub associated outbreak in Gallatin Co ..... February

LEGISLATION

Gov't Health Care Information Act changes ..... April
New fee structure for Public Health Laboratory ..... May

LEISHMANIA

Leishmania and the blood supply .....December

LICE

Head lice alert ..... August

MEASLES

Advisory ..... March
Alert ..... April
Update ..... May
Travel advisory ..... June
Recommendations ..... July

NURSES

Rural Nurses - 2nd Annual Summer Institute ..... March

PERTUSSIS

Chemoprophylaxis of pertussis ..... September

RUBELLA

Rubella alert ..... September

SAFETY

Safety alert - bunk beds ..... July
Product recall - pacifiers .....November
Recall of sporicidin solution .....December

SALMONELLOSIS

Alert ..... January

SCABIES

Scabies outbreak, Toole County .....November

SHIGELLA

Community outbreaks of shigellosis, Montana ..... October
Shigellosis control; tips and ideas ..... October

TICKS

Tick season approaches ..... March

TOBACCO

Smokeless tobacco use, Montana teens ..... October

VACCINE

Vaccine orders ..... January
Vaccine purchases for public providers ..... July
U.S. vaccination efforts need shot in the arm ..... August
Influenza vaccine update ..... September
Ordering vaccine from purchasing contracts .....December

JANUARY 1992	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1													
Big Horn		7													
Blaine		5													
Broadwater		1													
Carbon		1													
Carter															
Cascade		17	1	1			1						1	1	
Chouteau															
Custar		4													
Daniels															
Dawson		2													
Deer Lodge		1													
Fallon		1													
Fergus		2									1				
Flathead		2		1						1			1		
Gallatin	1	12	1		1			1							
Garfield		1													
Glacier		9		1		2									
Golden Valley															
Granite															
Hill		7	1										1	16	
Jefferson															
Judith Basin															
Lake		3		1											
Lewis & Clark		13		1		7	2	1					2		
Liberty															
Lincoln															
McCone															
Madison															
Meagher															
Mineral										1					
Missoula		28	3												
Musselshell		1													
Park		3													
Petroleum															
Phillips															
Pondera		3										1			
Powder River															
Powell															
Prairie															
Ravalli															
Richland															
Roosevelt		8				1		1							
Rosebud		1												5	
Sanders		1													
Sheridan															
Silver Bow		6											2		
Stillwater		1													
Sweet Grass															
Teton															
Toole															
Treasure															
Valley						1		1							
Wheatland															
Wibaux		1													
Yellowstone		47	3	4		2	1						2	6	
MONTHLY TOTAL 1992	1	189	9	9	1	13	4	4	0	2	1	1	9	28	0
MONTHLY TOTAL 1991	1	152	9	14	2	12	8	0	2	2	2	2	12	1	0
MONTHLY TOTAL 1990	1	133	8	12	2	3	3	0	0	2	15	3	5	2	0
TOTAL TO DATE 1992	1	189	9	9	1	13	4	4	0	2	1	1	9	28	0
TOTAL TO DATE 1991	1	152	9	14	2	12	8	0	2	2	2	2	12	1	0
TOTAL TO DATE 1990	1	133	8	12	2	3	3	0	0	2	15	3	5	2	0

OTHER DISEASES:

LEGIONELLOSIS: Yellowstone - 1
BAC. MEN. UNSPEC: Gallatin - 2
YERSINIOSIS: Flathead - 1
Q-FEVER: Sheridan - 1

E. COLI 0157:H7 : Cascade - 1
KAWASAKI SYNDROME: Cascade - 1
Yellowstone - 1
PRIMARY SYPHILIS: Cascade - 2

QUESTIONS ABOUT CANCER?

The National Cancer Institute has established a national network called the Cancer Information Service (CIS). It is a toll-free telephone information and referral service which also provides community outreach. CIS provides rapid access to state-of-the-art information on cancer prevention, screening, diagnosis, treatment and survivorship issues. CIS staff will work with local agencies and health care providers who serve high-risk groups. They also provide consultation in health education program design and evaluation.

The CIS is intended to serve 1) cancer patients, 2) families and friends of cancer patients, 3) members of the general public, and 4) health professionals. Trained information specialists will listen to the concerns of callers, explore their needs, provide personalized answers to cancer-related questions, and make referrals to community resources. CIS specialists obtain information through a custom computerized data base of community agencies, reference literature, and pamphlets. Another data base, PDQ (Physician's Data Query) lists information on state-of-the-art cancer treatment options, including research therapies used in clinical trials.

The Cancer Information Service®

1-800-4-CANCER

THE PUBLIC'S LINK TO CANCER INFORMATION

Volume: **Month of:**

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Montana Morbidity Report

VOL. 16 NO. 2 February 1992

Montana State Department of Health and Environmental Sciences

LYME DISEASE, MONTANA

Lyme disease is a tickborne illness caused by the spirochete Borrelia burgdorferi. The disease is usually characterized by an early skin lesion, erythema migrans (EM) and nonspecific systemic manifestations sometimes followed by involvement of the cardiac, neurologic or musculoskeletal systems in infected patients. Lyme disease often presents with symptoms that are easily confused with other diseases. Even EM has limitations in its diagnostic utility, since these lesions may be absent in up to 40% of acute cases. Allergic local responses to tick tissues, and other erythematous rashes can sometimes be mistaken for EM.

The diagnosis of Lyme disease is also complicated by the absence of a reliable serologic test. Current serologic tests for Lyme disease are relatively nonspecific. The predictive value of a positive test for antibodies to B. burgdorferi in non-endemic areas is very low, and the majority of positive results will be false-positive in these areas, including Montana. The current serologic tests are also hampered by a lack of standardization, leading to inter- and intra-laboratory variation in test results.

Surveillance for Lyme disease was initiated by CDC in 1982. Lyme disease was made a reportable condition in Montana, November 1987 and, in January 1991, it became reportable nationwide. Montana is one of only four states that have not reported endemic Lyme disease.

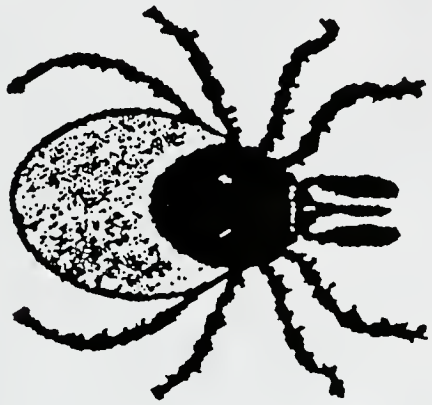
INDEX

LYME DISEASE, MONTANA 1
MONTANA TUBERCULOSIS SYMPOSIUM . . . 2
TUBERCULOSIS SCREENING 3
HIV IN CHILDBEARING WOMEN 5
MONTANA HIV/AIDS CONFERENCE 5
MONTANA RECEIVES RWJF GRANT 6
IMMUNIZATION CLINIC NOTICE 6
EPIDEMIOLOGY IN ACTION COURSE 6
MONTANA MORBIDITY 7

The Montana Department of Health and Environmental Sciences is examining the Lyme disease situation in Montana very carefully, because the presence of an agent or a vector has not been demonstrated in this State. Federal health officials from the Centers for Disease Control were called in this month to assist state workers in assessing the situation in Montana.

Attempts to establish the presence of Lyme disease in a new geographic area, such as Montana, cannot be based solely on clinical observations and serologic results. The emergence of risk for Lyme disease in an area can be evaluated by determining the presence of a suitable vector. Numerous species of ticks have been shown to capable of transmitting B. burgdorferi. In the U.S., competent vectors for transmission of the Lyme disease agent are the ticks Ixodes dammini, I. pacificus, I. scapularis, and I. dentatus. While ticks are abundant throughout Montana, these kinds have been shown to be incapable of transmitting Lyme disease. Physiologically-competent tick vectors for transmission of Lyme disease

have not been identified in Montana to date. The absence of these vectors is important evidence against the likelihood of endemic Lyme disease in Montana. Health care providers throughout Montana, however, are urged to continue to submit tick specimens from humans to MDHES for identification.



The only unequivocal way to establish the presence of Lyme disease in an area is to isolate the agent. Such evidence of the bacterium in man, animals or ticks in Montana is lacking. While the isolation of the organism from human specimens has generally been a low-yield procedure, culture methods have improved and isolation rates of 80% have been reported when culture is attempted on skin punch biopsies of EM lesions from patients with acute, early-stage illness. Clinicians who suspect Lyme disease in a patient should make a concerted effort to document this by obtaining appropriate specimens for culture.

Attempts to culture B. burgdorferi from human tissues will be facilitated by the Centers for Disease Control through the Montana Public Health Laboratory. Limited supplies of culture medium and sterile, skin-punch biopsy kits are available to physicians. CDC will cover shipping expenses, and will process the specimens. Culture medium, punch biopsy kits, mailing labels, shipping instructions, and information on specimen collection can be obtained by calling Susie Zanto at 444-2642. Health care providers are urged to make judicious use of this service.

MONTANA TUBERCULOSIS SYMPOSIUM

The Montana Department of Health and Environmental Sciences, and the Billings Area Indian Health Service are sponsoring a symposium on the treatment and control of tuberculosis. This training will be funded through a grant from the U.S. Public Health Service.

The first course offering will be held at the Grouse Mountain Lodge in Whitefish on April 28-29 preceding the 1992 Annual Montana Public Health Association Conference. Additional offerings will be in Wolf Point on May 12-13; in Great Falls on June 10-11; and in Billings on June 16-17. Physicians, and other private and public health care providers are encouraged to attend. Application has been submitted for the approval of continuing education credits.

Tuberculosis remains a serious problem in Montana and the nation. While the number of TB cases reported in the U.S. decreased annually from 1953 through 1984, this long-term downward trend has stopped, and marked increases in TB morbidity are being noted. The effects of increasing poverty, substance abuse, medication shortages, multiple drug resistant TB strains, incomplete treatments, health care provider indifference, and the AIDS epidemic are all contributing to the resurgence.

The objectives of the symposium are for each attendee to be able to:

- Apply current and new recommendations for the treatment of tuberculosis disease and infection.
- Understand the preventative measures for the transmission of TB in hospitals, and in the community.
- Identify predisposing factors and treatment approaches to multidrug-resistant TB.
- Recognize the barriers to case management and understand techniques for enhancing compliance.
- Respond to the impact of HIV on the control of TB.

There is no registration fee for this symposium. For more information, and registration instructions, please call Rita Harding at the Billings Area Indian Health Service; (406) 657-6941.

TUBERCULOSIS SCREENING

NOTE: *The rate of tuberculosis in the U.S. declined steadily until 1984. Since that time, the number of cases has increased each year. The increase has occurred primarily in populations that are difficult to reach, including refugees, homeless persons and the medically underserved. The increasing incidence of TB is also attributable to effects of the HIV epidemic and to the breakdown of latent disease in the elderly. Additional efforts need to be targeted to these high-risk populations. This is the first of a series of articles addressing tuberculosis prevention and control measures.*

INTRODUCTION

The Montana Department of Health and Environmental Sciences is committed to the national goal of tuberculosis elimination. As tuberculosis morbidity has receded into specific pockets of the population, community-wide screening has been replaced by targeted screening in high-risk population groups. Intensified screening and follow-up in these high-risk groups is essential to achieving the national goal of tuberculosis elimination

Most individuals infected with Mycobacterium tuberculosis do not experience clinical illness; infected individuals are usually asymptomatic and noninfectious. The only evidence of infection may be a reaction to a tuberculin skin test. Asymptomatic infection can persist in a person for years. Infected persons, however, can develop disease conditions, and become contagious at any time in their life, especially if their immune system becomes impaired.

Screening is done to identify asymptomatic infected persons who would benefit from preventive therapy, and to find infected persons with clinical disease who need treatment.

Responsibility for conducting screening will vary, depending upon local situations. Usually, the local health department assumes responsibility for conducting the screening. In some situations, however, the local health department alerts other appropriate officials (e.g., hospital infection control officers, employers, institutions, shelter operators) of the need for screening, and offers to assist in training and evaluation.

The standard screening method to identify persons infected with M. tuberculosis is the Mantoux tuberculin skin test. Accordingly, 0.1 ml of 5 TU of PPD is administered intracutaneously, and interpreted after 48-72 hours. While multiple puncture (Tine) tests are available, they should only be considered for use if screening large, low-risk populations. The disadvantage of the multiple puncture test is that the amount of tuberculin administered is not controlled. Positive multiple puncture test reactions should be verified by the standard Mantoux test. **Multiple puncture tests should not be used for tuberculin testing in high-risk populations.** Chest radiography or sputum smear examinations are the screening methods of choice only when the objective is intended to identify persons with current pulmonary disease, and when the administration of preventive therapy to infected persons is not possible (e.g., among the homeless). Pregnancy is not a contraindication to Mantoux testing; routine testing is often part of prenatal evaluation.

Certain groups have a higher incidence of tuberculosis than the general population. Screening and preventive therapy programs should be particularly effective for persons in these groups. The U.S. Centers for Disease Control has identified the following high risk groups, and recommends that they be screened for tuberculosis and tuberculous infection:

- Close contacts of persons known or suspected to have TB
- Persons infected with HIV
- Persons with medical risk factors known to increase the risk of disease
- Foreign-born persons from countries with high TB prevalence
- Medically underserved low-income populations
- Alcoholics and intravenous drug users
- Residents of long-term care facilities, correctional institutions, mental institutions, nursing homes/ facilities and other long-term residential facilities

RECOMMENDATIONS FOR SPECIFIC HIGH-RISK GROUPS

Contacts of Infectious Cases

Close contacts of TB cases need to have a Mantoux skin test as soon as possible. Because skin test sensitivity may take 2-10 weeks to develop, the Mantoux test should be repeated at least 10 weeks following the last exposure, or following the most recent exposure during which time the source case was considered infectious. For case contacts, a Mantoux reaction $\geq$ 5 mm induration is considered significant. A chest radiograph to rule out active disease should be performed on all reactors. Newly infected contacts should be offered preventive therapy regardless of age.

Persons with HIV

HIV infection is one of the major risk factors for progression of latent tuberculosis infection to active disease. All HIV-infected persons (with or without AIDS or other HIV-related disease), should be screened with a standard Mantoux skin test at the time of HIV diagnosis. False negative results may occur because of HIV-induced immunosuppression. Guidelines for anergy testing in the setting of HIV infection are available from the Montana Department of Health and Environmental Sciences by phoning 444-3986. A reaction $\geq$2 mm induration is considered significant.

Persons with Medical Risk Factors

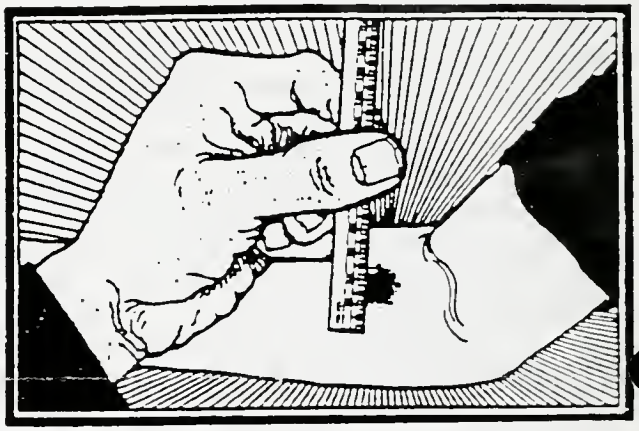
Medical risk factors which may increase the risk of tuberculosis include silicosis, gastrectomy, jejunoileal bypass, chronic renal failure, diabetes mellitus, prolonged high-dose corticosteroid therapy, other immunosuppressive therapy, some hematologic disorders (e.g, leukemia and lymphomas) and certain other malignancies.

The Foreign-Born

TB is a problem among persons who come to the U.S. from certain high-prevalence countries (most countries in Africa, Asia, and Latin America are high-prevalence countries). Foreign-born persons at risk include not only immigrants (legal and illegal), and refugees but also workers and students.

Medically Underserved/Low-Income Populations

The incidence of TB has been shown to be closely related to socioeconomic status, with the highest rates occurring among persons in low-income groups. Control strategies targeted toward low-income groups and their service providers (e.g., health, welfare, and housing) are indicated.



Persons in Other High-Risk Environments

These environments include prisons, jails, health care facilities, nursing homes and other long-term care facilities for the elderly and residential mental health facilities. Montana Administrative Rules require tuberculosis screening of new persons employed in public and private schools, and in day care facilities. Montana Rules also specify that patients admitted to or residing in a long-term care facility shall provide documentation by a physician that they are free from communicable tuberculosis at time of admission and annually thereafter.

Recommendations for screening in the above high-risk populations have been published by CDC and are available by calling the Montana Department of Health and Environmental Sciences at 444-3986.

HIV SEROPREVALENCE STUDY OF CHILDBEARING WOMEN IN MONTANA

Montana has recently completed its third year of participation in the Centers for Disease Control's Seroprevalence Study of Childbearing Women. Forty-five states participate in the study, each contributing its data to the largest blinded survey of HIV infection in the United States.

Excess blood spots that remain after the completion of metabolic screening of newborns are tested for maternal antibody to HIV. The survey design requires that all identifying information be removed prior to testing so that test results cannot be linked to any identifiable persons. In a blinded study, obtaining informed consent before testing is unnecessary. As a result, such studies eliminate the self selection bias present in unblinded studies.

As mentioned, a positive tests indicates that HIV infection is present in the mother, not necessarily the infant. Most current studies reflect that approximately 30% of the infants born to HIV positive mothers in the United States will be HIV infected.

Montana's study indicates a very low infection rate among women of childbearing age, typically 15-44, who have given birth in a Montana hospital since January of 1989. The table below reflects the data collected.

Summary of Data collected from the Seroprevalence Study of Childbearing Women - Montana, 1989 through 1991.

Year	No. of Tests	No. Positive	(%) Positive
1989	10,828	0	0
1990	10,811	3	.03
1991	11,698	0	0
TOTAL	33,337	3	.009

MONTANA AND HIV IN THE 90's SHARING THE CHALLENGE

A conference for Montana's HIV/AIDS health, prevention and community education network will be held May 27-29, 1992, on the Montana State University (MSU) campus, Bozeman. Sponsors of the conference are: Montana State University; Southwest Montana AIDS Coalition, Bozeman; Montana AIDS/STD Program; Northwest AIDS Education and Training Center Program, Seattle; Blue Cross & Blue Shield of Montana; and the Montana Gay Health Project.

The conference will feature Martin Delaney, Executive Director of Project Inform, a San Francisco based organization which provides information about promising drugs. He has worked closely with the FDA and other Federal agencies to streamline access to treatments. He is considered a leading authority on both the process of drug approval and new and promising therapies in the treatment of HIV disease.

Robert Runnels, Director of Dental Infection Control, University of Utah Medical School, will address the impact of AIDS on health care providers and the patients they see. Dr. Runnells is one of the lead investigators in the Kimberly Bergalis case and will be able to share some of the latest available findings.

Other noted presenters will be Dr. Elizabeth Harmon from the Lee County Schools, Fort Myers, Florida and Chris Steele, Chair of the Texas State Legislative Task Force on AIDS. Dr. Harmon has been a leader in AIDS curriculum development in Florida, one of the states with the largest number of HIV infected individuals outside large metropolitan areas. She will address the denial associated with HIV infection in a rural state and also relate useful strategies that we can use to overcome resistance to HIV education and prevention activities in our communities.

The conference will showcase some of Montana's outstanding community based AIDS organizations and their achievements as well as current research on HIV, Montana's own planning process and the 1993 legislative agenda. In addition, the two day schedule will include several panels and

workshops composed of families affected by HIV, persons with HIV infection, women, teens, Native Americans and Hispanics.

Registration is $45 for the full conference and $25 for a single day of attendance. Pending funding from the Centers for Disease Control, a number of scholarships will be available for individuals from regions where there are community-based AIDS organizations. For more information about the conference, contact: MSU - Office of Continuing Education for the Health Professional; 318 Montana Hall; Bozeman, MT 59717 (406 994-4930).

MONTANA RECEIVES ROBERT WOOD JOHNSON FOUNDATION GRANT TO DEVELOP CENTER FOR HEALTH STATISTICS

The Stephen's Administration has been awarded a $147,113 grant from the Robert Wood Johnson Foundation to develop plans for a Montana Cooperative Center for Health Statistics. The development of the Center is a cooperative venture of the Montana Department of Health and Environmental Sciences (MDHES) and the University of Montana. The Health Services Division of MDHES has been designated as the lead agency responsible for the planning project.

"Over the last three years we've demonstrated that improving health care in Montana is one of the highest priorities of our administration," Governor Stephens said. "Through this grant, the Robert Wood Johnson Foundation joins us as a partner in our efforts to meet the health care needs of Montanans." The center will be designed to provide legislators, health care professionals, policymakers and others with a central and unified system for easily accessing health care information and statistics.

Dr. Todd Damrow, State Epidemiologist with the Health Services Division at MDHES, and Dr. Richard Offner, Director of the Montana University Affiliated Rural Institute on Disabilities at the University of Montana, will direct the project. They will lead a ten member Interagency Working Group (IWG) in completing the planning process to establish the center. The IWG will be made up of individuals representing public and private health policy information concerns, and will be appointed by the Governor. The group will coordinate their efforts with the Governor's Health Care Oversight Committee to ensure that the planning process has both executive and legislative approval.

ATTENTION: PUBLIC IMMUNIZATION CLINIC OPERATORS

The time has come to submit your orders for the 2nd dose MMR.

A limited amount of extra 2nd dose MMR is available due to a vaccine funding increase from the legislature.

Please submit orders by phone (444-5580) to Liz if you are in need of more 2nd dose MMR than you currently have on hand or if the amount you received last year provided insufficient coverage to the students in the entering grade of the middle schools served by your facility.

Please have your order from last year available when placing this years order. Please let Liz know if you feel your clinic's present circumstance warrants more vaccine or less vaccine than last year.

EPIDEMIOLOGY IN ACTION COURSE

The U.S. Centers for Disease Control and Emory University will cosponsor a course designed for practicing state and local health department professionals. This course, **Epidemiology in Action**, will be held at CDC May 18-29. It emphasizes the practical application of epidemiology to the solution of public health problems and will consist of lectures, workshops, classroom exercises (including actual epidemiologic problems), roundtable discussions, computer training, and an on-site community survey. There is a tuition charge.

Applications must be received by March 16, 1992. Additional information and applications are available from Department PSB, Emory University, School of Public Health, 1599 Clifton Road, NE, Atlanta, GA 30329; phone (404) 727-3485 or (404) 727-0199.

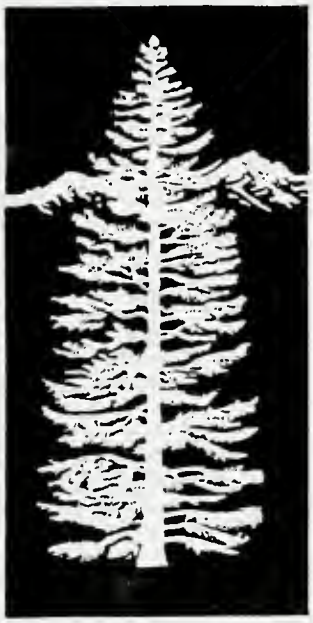
FEBRUARY 1992	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1												1	
Big Horn				1											
Blaine															
Broadwater															
Carbon															
Carter											2			3	
Cascade	1	14		1									1		
Chouteau													1		
Custer		9													
Daniels															
Dawson		1													
Deer Lodge						1									
Fallon															
Fergus		1													
Flathead		5													
Gallatin	1	13				1	1								
Garfield															
Glacier		12				4									
Golden Valley															
Granite		1												4	
Hill		3					1								
Jefferson		1													
Judith Basin															
Lake		1													
Lewis & Clark		11													
Liberty															
Lincoln		4													
McCone															
Madison															
Meagher															
Mineral															
Missoula		20		1		1	2								
Musselshell		1													
Park		2													
Petroleum															
Phillips															
Pondera		2													
Powder River															
Powell		1		1											
Prairie															
Ravalli		1										1			
Richland		1												1	1
Roosevelt		8													1
Rosebud		6													
Sanders								1							
Sheridan															
Silver Bow		5													
Stillwater		1													
Sweet Grass															
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		12		3											
MONTHLY TOTAL 19 92	2	167	3	3	0	7	5	0	0	1	3	0	2	9	2
MONTHLY TOTAL 19 91	9	178	3	3	1	13	9	1	0	1	2	1	10	0	0
MONTHLY TOTAL 19 90	1	126	11	17	1	15	12	1	1	1	2	4	5	3	0
TOTAL TO DATE 19 92	3	356	3	16	1	20	9	4	0	3	4	1	11	37	2
TOTAL TO DATE 19 91	10	330	18	22	3	25	17	1	2	3	4	3	22	1	0
TOTAL TO DATE 19 90	2	259	19	29	3	18	15	1	1	3	17	7	10	5	0

OTHER DISEASES:

CYTOMEG. VIR. ILL.: Yellowstone-1
YERSINIOSIS: FLATHEAD -1

ROCKY MOUNTAIN RENDEZVOUS

WELLNESS IN THE WILDERNESS



a conference to promote personal health and wellness

ROCK CREEK RESORT
RED LODGE, MONTANA
JUNE 28 - JULY 1, 1992

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WELLNESS IN THE WILDERNESS

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Plan now to attend this four-day conference! Through a series of presentations, workshops, and outdoor activities, you will explore the five dimensions of wellness:
· physical · social · intellectual · emotional · spiritual.

Rock Creek Resort lies just outside Red Lodge, Montana. Located in the spectacular Beartooth Mountains, this conference site provides the perfect atmosphere for a successful wellness experience.

WHO SHOULD ATTEND?

- *school employees*
- *health professionals & preprofessionals*
- *DRUG FREE schools personnel*
- *wellness & health promotion personnel*
- *fitness leaders*
- *personnel directors*
- *mental health professionals*
- *prevention, intervention & treatment personnel*
- *senior service providers*
- *anyone interested in personal health development*

FOR MORE INFORMATION, CALL 444-3985

Sponsored by the Montana Department of Health and Environmental Sciences, the Montana Office of Public Instruction, the Wyoming Department of Education, and MAHPERD

Volume: Month of:

MONTANA MORBIDITY REPORT. ISSN 0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

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HELENA, MONTANA 59620

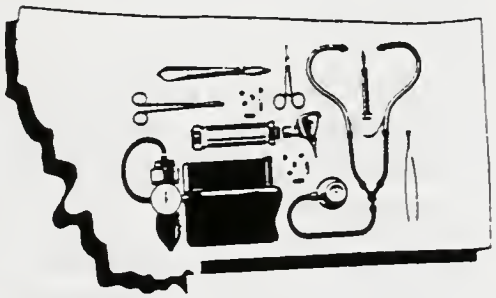
VOL. 16 NO. 3 March 1992

Montana State Department of Health and Environmental Sciences

PLEASE RETURN

GENITAL CHLAMYDIA INFECTIONS, MONTANA

Chlamydia trachomatis is the most prevalent sexually transmitted bacterial pathogen in the United States today. An estimated three to four million men, women and infants have chlamydial infections each year. Women, however, suffer most from the consequences of infection: pelvic inflammatory disease, tubal damage, and adverse outcomes of pregnancy. The direct and indirect costs of chlamydial infections in the United States have been estimated to be approximately 1.5 billion dollars annually.



Montana residents have not been exempt from the chlamydial problem. The incidence of reported genital chlamydial infections during 1991 continued to increase from previously reported years and is higher than the national average reported in 1988. The rate of reported cases in Montana during 1991 was 269 per 100,000 population. This rate increased from the 1990 rate of 198 cases per 100,000 population. During 1991 there were 35,212 reported tests for chlamydial infections performed in Montana. From that testing, 2,199 people were found to be positive for a positivity rate of 6.2 percent.

INDEX

GENITAL CHLAMYDIA, MONTANA	1
CHOLERA IN THE NINETIES	2
COCCIDIODOMYCOSIS ALERT	3
"BUT I KNOW ABOUT THIS CASE"	3
MONTANA REPORTABLE DISEASES	4
INH PREVENTIVE THERAPY	5
AIDS/STD BRIEFS	7
TREATING A CHILD'S FEVER	7
RESIDENT AND NON-RESIDENT AIDS	8
MONTANA MORBIDITY	9

While Chlamydia trachomatis infections are not a reportable sexually transmitted disease nationally, most states have now made it reportable. Chlamydia infections have been reportable in Montana since 1987 and, since then, the number of reported cases has increased. Whether this is due to increased surveillance and reporting, or due to an actual increase in the incidence of the disease, or a combination of the two is unknown.

The year 2000 National Health Objective for chlamydial infections is to reduce to a level of no more than 170 cases per 100,000 people. It is apparent that Montana health care providers are faced with the difficult problem of reducing the incidence to meet that goal. Only a concerted effort during the next few years will allow Montana to reach an acceptable level.

CHOLERA IN THE NINETIES

After an absence of nearly a century, epidemic cholera has reappeared in the Americas. Hundreds of thousands of cases of cholera have been reported in the past year in many South American countries. The death toll is estimated to be around 4,000, but officials have concluded that the numbers would have been much higher if modern treatment had not been available.

Several domestic cases of cholera were traced to food brought into the United States from South America. In one case, cooked crabs were smuggled into the country and served at a small dinner party. Several guests became sick and were diagnosed with cholera. The safest rule is to not bring food back into the United States after travelling to South America. The risk of getting cholera during international travel is believed to be low, less than one case per 500,000 U.S. travellers.

Cholera Caution: Some Questions and Answers

Q. What is cholera?
A. Cholera is an acute, diarrheal illness caused by infection of the intestine with the bacterium *Vibrio cholerae 01*. The infection is often mild or without symptoms, but sometimes it can be severe. Approximately one in 20 infected persons has severe disease characterized by profuse watery diarrhea, vomiting, and leg cramps. In these persons, rapid loss of body fluids leads to dehydration and shock. Without treatment, death can occur within hours.

Q. How does a person get cholera?
A. A person may get cholera by drinking water or eating food contaminated with the cholera bacterium. In an epidemic, the source of the contamination is usually the feces of an infected person. The disease can spread rapidly in areas with inadequate treatment of sewage and drinking water. The disease is not likely to spread directly from one person to another; therefore, casual contact with an infected person is not a risk for becoming ill.

Q. Is a vaccine available to prevent cholera?
A. A vaccine for cholera is available; however, it confers only brief and incomplete immunity and is not recommended for travelers. There are no cholera vaccination requirements for entry or exit in any Latin American country or the United States.

Q. What should travelers do to avoid getting cholera?
A. All travelers to areas where cholera has occurred should observe the following recommendations:

- Drink only water that you have boiled or treated with chlorine or iodine. Other safe beverages include tea and coffee made with boiled water and carbonated, bottled beverages with no ice.
- Eat only foods that have been thoroughly cooked and are still hot, or fruit that you have peeled yourself.
- Avoid undercooked or raw fish or shellfish, including ceviche.
- Make sure all vegetables are cooked - avoid salads.
- Avoid foods and beverages from street vendors.
- Do not bring perishable seafood back into the United States.

COCCIDIOIDOMYCOSIS ALERT

In late November and December, large dust storms in California resulted in the widespread airborne dissemination of Coccidioides immitis spores. Montana physicians are advised to consider the possibility of coccidioidomycosis in the differential diagnosis of patients with pulmonary illness and a history of travel to the Central Valley of California during this time.

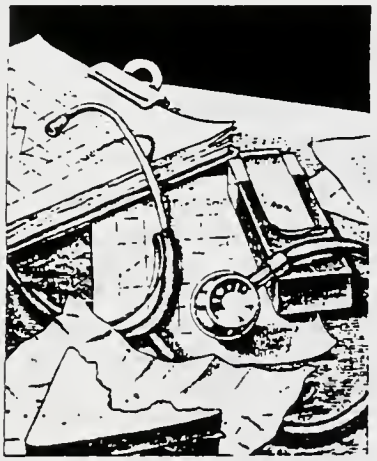
Most infections are asymptomatic or mild, but some individuals have developed moderate to severe influenza-like illness, pneumonia, and/or disseminated disease. The spectrum of disease for this systemic mycosis may range from inapparent to resembling an acute respiratory illness with fever, chills, cough and pleural pain, to a progressive granulomatous disease characterized by lung lesions and abscesses throughout the body, especially in subcutaneous tissues, skin, bone, peritoneum, testes, thyroid and the CNS.

Most cases have been reported among residents of California, but travellers in the area have also been affected. Several fatalities have been reported. Serologic tests are available through the Montana Public Health Laboratories. Although coccidioidomycosis is not an officially reportable disease, if you confirm the diagnosis in one of your patients, the Epidemiology Office would be interested in hearing of such a case. Contact Todd Damrow at 444-3986.

"BUT I KNOW ABOUT THIS CASE...."

The Montana Department of Health and Environmental Sciences frequently receives phone calls requesting disease statistics. Two of these requests came from workers in Montana hospitals; one was interested in Q-fever, and the other was preparing a presentation on mosquito-borne encephalitis. When told that there were not any cases of these diseases reported in their area during 1991, both responded with knowledge of specific cases which had been treated in their hospitals, which may have prompted their academic interest. They were dismayed to learn that their respective hospitals had not reported. Fortunately, MDHES was able to fill in this missing data with some assistance from either the caller or the infection control nurse from the hospital.

Attached, in this issue of the Montana Morbidity Report, is a listing of the disease conditions reportable in Montana. According to our State's Administrative Rules, any person, including but not limited to a physician, dentist, nurse, other health care practitioner, administrator of a health care facility, public or private school administrator, city health officer, or laboratorian who knows or has reason to believe that a case exists shall report the information to the county, city-county, or district health officer. For more information, please contact your local health department, or the Montana Department of Health and Environmental Sciences, Epidemiology Office (444-3986).



REPORTABLE DISEASES

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

HEALTH SERVICES DIVISION

COGSWELL BUILDING — HELENA, MONTANA 59620

T = Immediately Telephone Case Report

X = Report on Confidential Case Report Card

	Telephone or Mail Daily	Mail Within 7 Days	Mail Weekly Numbers Only
Amebiasis		X	
Anthrax	T		
Aquired Immune Deficiency Syndrome		X	
Botulism (including infant)	T		
Brucellosis		X	
Campylobacter enteritis		X	
Chancroid	X		
Chickenpox			X
Chlamydial genital infection		X	
Cholera	X		
Colorado Tick Fever			X
Conjunctivitis, epidemic			X
Cytomegaloviral illness		X	
Diarrheal disease outbreaks	X		
Diphtheria	T		
Encephalitis		X	
Gastroenteritis epidemic	X		
Giardiasis		X	
Gonococcal infection	X		
Granuloma Inguinale	X		
Haemophilus influenzae B inv. dis.	X		
Hansen's disease (leprosy)		X	
Hepatitis, A		X	
Hepatitis, B		X	
Hepatitis, Non A—Non B		X	
Hepatitis, unspecified		X	
Influenza (confirmed)			X
Kawasaki disease		X	
Legionellosis		X	
Listeriosis	X		
Lyme disease		X	
Lymphogranuloma Venereum	X		
Malaria		X	
Measles (Rubeola)	T		
Meningitis, bacterial or viral	X		
Mumps		X	
Ornithosis (Psittacosis)		X	
Pertussis (whooping cough)	X		
Plague	T		
Poliomyelitis	X		
Q-fever		X	
Rabies or exposure (human)	T		
Reye's Syndrome		X	
Rocky Mountain Spotted Fever		X	
Rubella (including congenital)	X		
Salmonellosis		X	
Shigellosis		X	
Smallpox (including vaccinia)	T		
Staphylococcal epidemic			X
Streptococcal epidemic			X
Syphillis	X		
Swimmer's Itch			X
Tetanus	X		
Trichinosis		X	
Tuberculosis		X	
Tularemia		X	
Typhoid fever	T		
Typhus	X		
Yellow fever	X		
Yersiniosis		X	
Illness in a foreign traveler	X		
An unusual outbreak of any communicable disease	X		

Report to your local health officer:

Name: _____

Phone: _____

If unable to contact local health officer, contact:
STATE DEPT. OF HEALTH & ENV. SCIENCES
Cogswell Bldg.
Helena, MT 59620
ATTN: Communicable Disease Control

Revised 12/22/87

INH Preventive Therapy

Note: *The rate of tuberculosis in the U.S. declined steadily until 1988. Since that time, the number of cases has increased each year. The increase has occurred primarily in populations that are difficult to reach, including refugees, homeless persons, and the medically underserved. The increasing incidence of TB is also attributable to effects of the HIV epidemic and to the breakdown of latent disease in the elderly. Additional efforts need to be targeted to these high-risk populations. The previous issue of the Montana Morbidity Report presented guidelines for tuberculosis screening. This issue presents the current CDC recommendations for prescribing preventive therapy with INH. This is the second of a series of articles addressing tuberculosis prevention and control measures.*

Isoniazid (INH) preventive therapy is the cornerstone of the plan to eliminate tuberculosis from the United States. When taken as prescribed, INH preventive therapy is highly effective in preventing latent TB infection from progressing to clinically apparent disease. Additionally, INH preventive therapy has been shown to be reasonably cost-effective.

The following recommendations of the Advisory Committee for Elimination of Tuberculosis, are intended to increase the effective application of preventive therapy in the U.S. Clinical decisions regarding preventive therapy must be individualized and based on an assessment of benefits and risks. These recommendations are intended to assist physicians and patients in making these decisions.

The purposes of preventive therapy are 1) to prevent latent (asymptomatic) infection from progressing to clinical disease, 2) to prevent initial infection, and 3) to prevent recurrence of past disease.

INH preventive therapy should be given to all persons with a positive Mantoux PPD tuberculin skin test who are 34 years of age or younger, have a chest X-ray that is negative for active TB, and have not previously been treated. Children and adolescents who have been close contacts of infectious cases of TB within the past three months are candidates for preventive therapy, even with a negative skin test, until a repeat skin test is done 12 weeks after the last contact with the infectious case.

Regardless of age, the following persons with a positive skin test should be considered for INH preventive therapy, if they have not previously been treated:

- Persons with HIV infection
- Close contacts of persons with active TB
- Persons who have chest radiographs consistent with old, healed tuberculosis
- Recent converters
- IV drug users
- Persons with medical conditions that may increase the risk of TB. These medical conditions include: silicosis, gastrectomy, jejunoileal bypass, diabetes mellitus, chronic renal failure, 10% or more below ideal body weight, conditions requiring prolonged high-dose corticosteroid and other immunosuppressive therapy, some hematologic disorders (e.g., leukemia, lymphonas) and other malignancies.

The criteria for determining need for preventive therapy is summarized in Table 1.

TABLE 1. Criteria for determining need for preventive therapy for persons with positive tuberculin reactions, by category and age group

Category	Age group (yrs)	
	<35	≥35
With risk factor*	Treat at all ages if reaction to 5TU purified protein derivative (PPD) ≥10 mm (or ≥5 mm and patient is recent contact, HIV-infected, or has radiographic evidence of old TB)	
No risk factor High-incidence group†	Treat if PPD ≥10 mm	Do not treat
No risk factor Low-incidence group	Treat if PPD ≥15 mm§	Do not treat

*Risk factors include HIV infection, recent contact with infectious person, recent skin-test conversion, abnormal chest radiograph, intravenous drug abuse, and certain medical risk factors (see text).

†High-incidence groups include foreign-born persons, medically underserved low-income populations, and residents of long-term-care facilities.

§Lower or higher cut points may be used for identifying positive reactions, depending upon the relative prevalence of *Myobacterium tuberculosis* infection and nonspecific cross-reactivity in the population.

STUMP THE CDC EXPERTS?

Q: We recently looked for the guidelines on which skin-test negative household contacts of an active case of tuberculosis should be started on preventive therapy and retested 3 months later. Are there age guidelines?

- Submitted by Neal Holtan, M.D., M.P.H.
Saint Paul Public Health Department
Saint Paul, Minnesota

A: The "Control of Tuberculosis," published by the American Thoracic Society and the Centers for Disease Control (Am Rev Resp Dis 1983; 128:336-352), contains guidelines for conducting contact investigations and reviews the approach to treatment of contacts. This document states that even when the initial reaction to a tuberculin skin test is negative (< 5 mm reaction), a contact should be offered preventive therapy, unless contraindicated, when the transmission risk factor data suggest a high probability of infection, when evaluation of other contacts with a similar degree of exposure demonstrates high prevalence of infection, or when the implications of not treating potentially evolving disease are great (e.g., in infants, young children, or persons with impaired immunity). The last category includes HIV-infected persons. In addition, "The Use of Preventive Therapy for Tuberculous Infection in the United States," published by the Advisory Council for the Elimination of Tuberculosis (ACET) (MMWR 1990:39 [no. RR-8]:9-12), reviews this issue. This document emphasizes the use of preventive therapy for skin-test negative contacts who are children and adolescents.

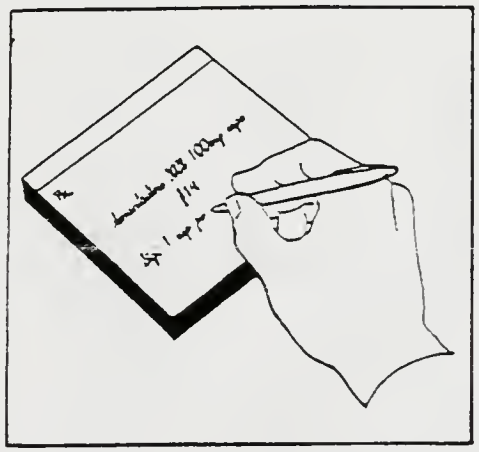
Although these two documents have slightly different emphases, there is no basic contradiction. Persons who are at high risk for tuberculous infection because of recent exposure should be considered for preventive therapy. Because the staff of tuberculosis control programs often must set priorities for prevention activities, these documents taken together suggest that children and adolescents should be among the highest priority of the skin-test-negative contacts for receiving preventive therapy. Certainly HIV-infected persons should also have high priority. When possible, however, all contacts to infectious cases of tuberculosis who fall into one of the categories noted in the Control Statement should be considered for preventive therapy.

- Response by Bess Miller, M.D., M.Sc.
Division of Tuberculosis Elimination

The usual preventive therapy regimen is INH at 10 mg/kg daily for children, up to a maximum adult dose of 300 mg daily. Twelve months of therapy are recommended for persons with AIDS/HIV infection and persons with stable abnormal chest X-rays consistent with past TB infection. Other persons should receive a minimum of 6 continuous months of therapy.

Contraindications include:

- Progressive TB (more than one drug is needed)
- Adequate course of INH previously completed
- Previous severe adverse reaction to INH
- Previous INH-associated hepatic injury
- Acute lever disease of any etiology



Patients should be thoroughly educated about possible side effects, and should be monitored monthly, in person, by trained personnel. INH preventive therapy should not be prescribed if monthly monitoring cannot be done. Special conditions that warrant careful monitoring include persons concurrently using other medications (possible drug interactions), or persons using alcohol daily (increased risk of INH-associated liver injury), or persons with current chronic lever disease (difficulty in evaluating changes in hepatic function). In pregnancy, it is prudent to defer treatment until postpartum unless the person is a close contact to an infectious case, is a new infection, or if some other urgent indication exists.

AIDS/STD BRIEFS

- The Montana Public Health Laboratory reports that 126 (6.5%) of 1,925 samples collected for Chlamydia screening were positive for the month of February (1992).

- Estimates of the chance of receiving an HIV-infected transfusion vary from one in 250,000 to one in 40,000 units of blood. A Red Cross Study reported in 1989 that the risk was one in 153,000. (American Red Cross HIV/AIDS Instructor Manual)

- It is currently estimated that 600-900 Montanans, or about 1 in 1000, are HIV infected. Given the present treatments available, most, if not all of those currently infected, will develop AIDS.

- During state fiscal year 1991 (July 1990 to June 1991), an estimated $1.4 million were spent for HIV/AIDS related treatment and prevention efforts in the state of Montana. Federal expenditures accounted for nearly 88% of this total. Medical services provided to Medicaid recipients accounted for most of the state dollars expended for HIV/AIDS. (Estimate prepared by MDHES AIDS Program).

Treating a Child's Fever

Reye syndrome is a rare but sometimes fatal condition in children and teens. While its cause is unknown, studies have linked the onset of the disease to aspirin use during a bout with the flu or chickenpox.

No link between aspirin use during other childhood diseases and Reye has been established. But, when a child begins running a fever, it is difficult—if not impossible—to know whether a child is suffering from flu, chickenpox, or some other illness. Therefore, most doctors now advise against using aspirin for any childhood fever and recommend using acetaminophen (brand names include Tylenol and Tempra) instead.

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES[1]
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - As of March 31, 1992

1. Disease Category	Adult/Adolescent Cases (%)	Adult/Adolescent Deaths (%)	Pediatric Cases (%)	Pediatric Deaths (%)	Total Cases (%)	Total Deaths (%)
PCP	48 (41)	39 (81)	1 (50)	1 (100)	49 (41)	40 (82)
Other Disease w/o PCP	66 (56)	43 (65)	1 (50)	0 (0)	67 (56)	43 (64)
KS Alone	3 (3)	0 (0)	0 (0)	0 (.)	3 (3)	0 (0)
No Diseases Listed	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Total	117 (100)	82 (70)	2 (100)	1 (50)	119 (100)	83 (70)

2. Age	Cases (%)
Under 13	2 (2)
13-19	2 (2)
20-29	31 (26)
30-39	50 (42)
40-49	24 (20)
Over 49	10 (8)
Unknown	0 (0)
Total	119 (100)

3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
White, Not Hispanic	104 (89)	0 (0)	104 (87)
Black, Not Hispanic	2 (2)	0 (0)	2 (2)
Hispanic	4 (3)	0 (0)	4 (3)
Native American	7 (6)	2 (100)	9 (8)
Unknown	0 (0)	0 (0)	0 (0)
Total	117 (100)	2 (100)	119 (100)

4. Exposure Category	Adult/Adolescent Males (%)	Adult/Adolescent Females (%)	Adult/Adolescent Total (%)
Homosexual or Bisexual Men	72 (69)	0 (0)	72 (62)
Intravenous (IV) Drug User	11 (10)	1 (8)	12 (10)
Homo/Bi IV Drug User	11 (10)	0 (0)	11 (9)
Hemophiliac	5 (5)	0 (0)	5 (4)
Heterosexual Contact	0 (0)	7 (58)	7 (6)
Transfusion With Blood/Products	1 (1)	3 (25)	4 (3)
None of the Above/Other	5 (5)	1 (8)	6 (5)
Total	105 (100)	12 (100)	117 (100)

	Pediatric Males (%)	Pediatric Females (%)	Pediatric Total (%)
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
None of the above/Other	0 (0)	0 (0)	0 (0)
Total	1 (100)	1 (100)	2 (100)

As of March 31, 1992 there have been 339 cumulative positive HIV tests from 34,431 tests conducted through the MDHES Public Health Laboratory since 1985.

In addition to the military screening at the DHES Public Health Laboratory, 17,601 civilian applicants for military service from Montana have been screened through the Department of Defense as of December 1991, with two positive for HIV.

Nationally, as of February 29, 1992, 213,621 cases of AIDS and 138,395 deaths have been reported to the Centers for Disease Control.

Source: Montana AIDS/STD Program, MDHES, through March 31, 1992. Please contact Jim Murphy at 444-4744 if you have questions or comments.

March-1992

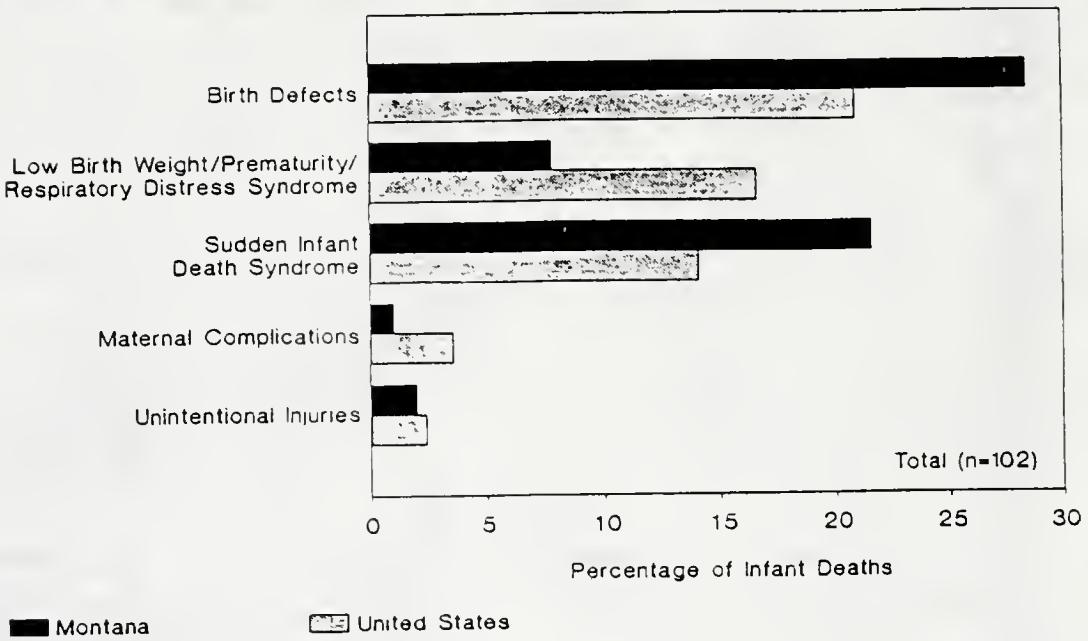
[1] Includes 89 Montana AIDS cases and 30 cases reported to Centers for Disease Control from other states who moved to Montana.

MARCH 1992	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2												1	
Big Horn		8													
Blaine	1														
Broadwater															
Carbon															
Carter															
Cascade	1	27	4				1							6	
Chouteau				1									1		
Custer		2													
Daniels															
Dawson		4		1											
Deer Lodge		1						1							
Fallon															
Fergus		2												1	
Flathead		6					1								
Gallatin		13	1										1		
Garfield															
Glacier		7		1		1								2	
Golden Valley															
Granite															
Hill		4								1				1	
Jefferson										1					
Judith Basin															
Lake		5		1											
Lewis & Clark		7	1					1							
Liberty															
Lincoln		1													
McCone															
Madison															
Meagher															
Mineral															
Missoula		13		1						2	2		2		
Musselshell		1													
Park		3				1									
Petroleum															
Phillips							1								
Pondera		1													
Powder River															
Powell															
Prairie															
Ravalli		1													
Richland															
Roosevelt		5												3	
Rosebud		1													
Sanders															
Sheridan		1		1											
Silver Bow		7						1							
Stillwater															
Sweet Grass									1						
Teton															
Toole															
Treasure															
Valley		1							1						
Wheatland															
Wibaux															
Yellowstone		43							2						
MONTHLY TOTAL 19 92	3	168	7	6	0	2	5	6	0	4	2	0	5	16	0
MONTHLY TOTAL 19 91	4	134	9	2	0	16	5	1	1	1	5	1	24	2	0
MONTHLY TOTAL 19 90	5	136	23	14	1	8	11	1	2	1	2	2	9	14	4
TOTAL TO DATE 19 92	6	524	15	22	1	17	17	7	1	7	6	1	16	53	2
TOTAL TO DATE 19 91	14	464	27	10	3	41	22	2	3	4	9	4	34	2	3
TOTAL TO DATE 19 90	7	395	42	43	4	26	26	2	3	4	19	9	19	19	4

OTHER DISEASES:

LEGIONELLOSIS: Beaverhead - 1
KAWASAKI SYNDR.: Glacier - 1

Leading Causes of Infant Mortality
Montana and United States, 1988



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VOL. 16 NO. 4 April 1992

Montana State Department of Health and Environmental Sciences

RABIES IN MONTANA, 1991

The Veterinary Diagnostic Laboratory at Montana State University and the Montana Department of Livestock tested a total of 783 animals for rabies during 1991. Overall, 41 (5.2%) were confirmed positive for rabies (Table 1). Of the specimens tested, 483 (61.7%) were from domestic animals (cats, dogs, cattle), 300 (38.3%) were from wild animals (skunks, bats, rodents). As shown in Figure 1, the largest proportion of positive animal rabies tests occurred among skunks (59%) and bats (41%).

INDEX

RABIES IN MONTANA	1
MONTHLY HIV/AIDS STATS	3
STD CONTROL BENEFITS	3
FDA TOLL-FREE LINE	4
AIDS/STD BRIEFS	4
ORDER FLU VACCINE	4
MONTANA MORBIDITY	5
U.S. TB RATES, 1988-1990	6

PLEASE RETURN

In 1991, specimens submitted from 20 counties were positive for rabies (Table 2). Although the distribution of rabies-positive animals by county and by species helps to determine trends in occurrence, this information alone should not be used in determining the need for post-exposure rabies prophylaxis. Animals selected for testing do not represent a random sample, therefore results do not represent the true prevalence of infection among species or in counties throughout the state.

When determining the need for rabies prophylaxis, physicians should consider the probability of an exposure, (i.e., inoculation of rabies virus through skin or on mucous membranes), circumstances regarding the exposure (provoked versus unprovoked attacks), the species of the animal from which the exposure occurred, and whether the animal is available for observation or testing. Healthy dogs and cats are quarantined for ten days where there has been a human exposure; it is recommended that all other animals be laboratory tested for rabies. No human rabies cases in this country have ever been associated with a rodent exposure, so that unless the circumstances of the bite are highly unusual (such as a truly unprovoked attack by a free-living rodent) these animals can be assumed rabies-free and no testing is required.

(continued on Page 2)

As long as rabies remains enzootic in skunks, all other mammals are potentially at risk for rabies. Currently, there is no reliable way to control rabies, except in domestic species. Therefore, all dogs and cats should be immunized. Montana law prohibits the possession of wild animals (skunks, foxes, raccoons, bats) as pets (MCA, 50-23-102).

TABLE 1.
ANIMAL RABIES TESTS
MONTANA, 1991

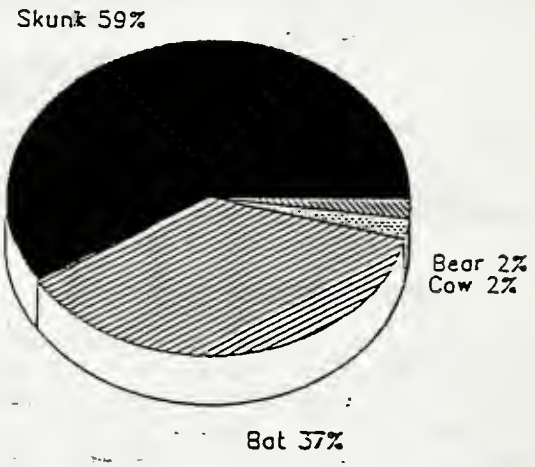
ANIMAL	POS	NEG
Antelope	0	1
Badger	0	1
Bat	15	97
Bear	1	1
Bird	0	1
Bobcat	0	1
Cat	0	219
Cattle	1	52
Chipmunk	0	2
Coyote	0	15
Deer	0	1
Dog	0	202
Ferret	0	1
Fox	0	7
Gopher	0	4
Hamster	0	3
Horse	0	7
Llama	0	2
Mink	0	2
Mouse	0	11
Muskrat	0	7
Rabbit	0	3
Racoon	0	46
Rat	0	3
Sheep	0	3
Skunk	24	84
Squirrel	0	6
Vole	0	1
TOTAL	41	783

Following are some precautions that persons can take to avoid possible exposure to rabies;

- Avoid animals that are acting in an unusual manner.
- Unprovoked attacks by any carnivorous animals may indicate rabies. Report them to your physician or health department.

Figure 1.

Positive Animal Rabies Tests*
Montana, 1991



*Animal-specific proportions (N=41)

- Do not adopt wildlife as pets; it is dangerous...and unlawful.
- Teach children to stay away from wild animals and unknown dogs and cats. Be sure they report any animal bites or scratches immediately.
- Obey animal control ordinances and leash laws.
- Be careful is assisting injured animals... they are often in pain and likely to bite.
- Be aware that there is a safe vaccine for people exposed to rabies, but to be effective it must be administered soon after exposure.
- Follow your veterinarians recommendation to vaccinate your pets against rabies. Protecting our pets creates an effective barrier between wildlife rabies and people. Even homes are not "bat proof." Therefore, house cats should also be vaccinated.

These recommendations were adopted from a brochure released by Connaught Laboratories entitled "Protecting Yourself from Rabies." Copies can be obtained by calling 1-800-VACCINE.

(continued on Page 3)

Table 2

COUNTY-SPECIFIC DISTRIBUTION
OF POSITIVE RABIES SPECIMENS,
BY SPECIES, IN MONTANA, 1991

COUNTY	Skunk	Bat	Cow	Bear
Big Horn	1			
Carbon	1			
Cascade	2	3		
Fergus	1	2		
Flathead	1			1
Gallatin		2		
Judith Basin	1			
Lewis & Clark		2		
Missoula		3		
Phillips	3			
Pondera	2			
Ravalli		2		
Roosevelt	1			
Sheridan	4			
Stillwater		1		
Teton	2		1	
Toole	1			
Valley	1			
Wibaux	1			
Yellowstone	2			
Total	24	15	1	1

In 1991, a total of 66 animal exposures were reported to DHES which resulted in post-exposure rabies prophylaxis. No cases of human rabies were reported in Montana during 1991. Pre-exposure rabies vaccination is available and recommended for veterinarians, animal control workers, and those who work with wildlife. Workers with frequent or continuous exposures should have boosters and/or a titer check every two years following initial vaccination; serology is preferred.

Rabies should be considered in any patient with a rapidly progressive encephalitis of unknown etiology, particularly in those who have had an exposure of other close contact with a recognized reservoir of the disease. One hallmark of rabies is its rapid progression to death. No survivors have been reported since 1977.

Consultation on rabies prevention and control is available from the Epidemiology office by calling 444-3986 during working hours, and by calling 444-4740 on evenings, weekends and holidays.

MONTHLY HIV/AIDS STATISTICS AVAILABLE

If you are interested in receiving the MDHES monthly statistics of HIV/AIDS in Montana on regular basis please call Jim Murphy, (444-4744) and he will put your name on the MDHES mailing list.

BENEFITS OF STD CONTROL ACTIVITIES

Many public health programs have their impact by preventing infections and disease complications. The prevention impact of an STD prevention program has probably been the least well recognized. Contemporary medical literature is replete with data documenting the rates of STD transmission, the frequency of sequelae, and costs associated with these complications. Using these data, it is possible to measure the prevention impact of STD program efforts in terms of both morbidity and disease consequences averted and cost savings to health care delivery in this country.

Women and children are the singular beneficiaries of strategies for STD prevention. For example, screening programs that identify and treat women in the uncomplicated stages of either gonorrhea or chlamydia are common practice. The literature clearly demontrates that this activity prevents 10-20 percent of these women with gonorrhea and from 8-40 percent of those with chlamydia from developing pelvic inflammatory disease (PID).

The Institute of Health Policy Studies, University of California, San Francisco, has documented the costs associated with this complication as well as the costs and occurrences of infertility and ectopic pregnancy that are additionally prevented through the early identification and treatment of these infections. For fiscal year 1991, it is estimated that gonorrhea and chlamydia screening and partner notification activities prevented 36,522-131,966 women nation-wide from an episode of PID, which saved between $53.4 and $193.1 million in direct health care costs for PID and an additional $15.5 to $56 million in direct costs of infertility and ectopic pregnancy. Indirect costs, representing the value of decreased output by women suffering PID and PID-associated disability, are another important part of prevention efforts. Indirect costs consist of lost wages and the value of household management that is not performed because of PID-related illness. In 1991, it is estimated that STD prevention efforts saved between $42 to $153 million in indirect costs. The benefit-to-cost ratio of gonorrhea screening and outreach efforts are estimated to be from 1.9:1 to 3.7:1; for chlamydia prevention activities, the ratio is estimated to range from 1.5:1 to 7.3:1.

Clearly, screening programs that identify and treat uncomplicated gonorrhea and chlamydia infections help to save valuable health care resources.

Reference: DSTD/HIVP Annual Report for 1991, Centers for Disease Control, Public Health Service.

FDA TOLL-FREE LINE FOR HEALTH PROFESSIONALS

The U.S. Food and Drug Administration has established a toll-free telephone service for health professionals. Physicians, pharmacists, nurses, veterinarians, and other health professionals can use it to ask questions about the agency's policies on medical advertising, marketing and promotion and to discuss promotional activities and practices for health care products that may require FDA attention. The service is designed to cover issues involving drugs, biologicals, medical devices, and veterinary products. When appropriate, FDA will refer calls to outside medical, industry, and trade organizations who have agreed to accept them.

The main number is 1-800-238-7332, and is answered by medical staff in the FDA Office of Health Affairs during normal business hours. Automatic answering equipment allows callers to record requests for information or leave messages at other times. FAX transmission of documents is available during and after business hours at 1-800-344-3332.

AIDS/STD Briefs

- CDC advises that all patients with TB should be offered counselling and HIV-antibody testing because the medical management of TB may be altered in the presence of HIV infection.
- MDHES' Behavior Risk Factor Surveillance Survey results show that the knowledge about HIV/AIDS and transmission is increasing in Montana. (See related article)
- CDC releases new PSAs on HIV/AIDS which are targeted at rural America, and include the MDHES Montana AIDS Hotline 1-800-233-6668. Look for them on your local stations.
- Two cases of primary syphilis and 23 cases of gonorrhea were reported during the first quarter of 1992. Chlamydia infections continue to be the most common STD in Montana. Public providers identified 376 cases of chlamydia infections during the first three months of 1992.

ORDER FLU VACCINE NOW

To ensure adequate supplies of vaccine for your agency this fall, order vaccine supplies now. All orders should be placed by June 15th for guaranteed delivery.

A state term contract for purchase of influenza vaccine is available to any state agency or county health department. Connaught Laboratories is the vendor and split virus, 10-dose vials cost $17.85 with $32.55 for 10 prefilled syringes. The purchaser is responsible for opening their own account with Connaught if necessary. Please contact Connaught directly to place orders. The Connaught phone number: 1-800-VACCINE. The Montana term contract number is 343-N.

Those administering the vaccine have a "duty to warn" and the Important Information Forms will be made available upon request from the DHES Immunization Program.

If you have any further questions, please call the Immunization Program at 444-5580.

APRIL 1992	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		4													
Big Horn		2													
Blaine		1													
Broadwater															
Carbon		3										1			
Carter															
Cascade		14	1	1		1		1						17	
Chouteau															
Custer		3													
Daniels												1			
Dawson		1											1		
Deer Lodge		2													
Fallon															
Fergus		1													
Flathead		7	2											1	
Gallatin		18		1						1					
Garfield															
Glacier		8												27	
Golden Valley		1													
Granite															
Hill		7													
Jefferson		1					1								
Judith Basin															
Lake		3													
Lewis & Clark		6					1	1							
Liberty															
Lincoln															1
McCone															
Madison															
Meagher															
Mineral															
Missoula	2	18	2				1				1		1		
Musselshell		2													
Park		5													
Petroleum															
Phillips															
Pondera															
Powder River															
Powell		2		1											
Prairie															
Ravalli		3													
Richland		1						1							
Roosevelt		7												3	
Rosebud		7		2							1				
Sanders															
Sheridan												3			
Silver Bow	1	13		2						1					
Stillwater															
Sweet Grass											1				
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		42	1	3			1	2					3	1	1
MONTHLY TOTAL 19 92	3	181	6	10	0	1	4	5	0	2	3	5	5	49	2
MONTHLY TOTAL 19 91	3	137	1	14	0	7	6	1	1	0	13	3	8	2	0
MONTHLY TOTAL 19 90	9	128	8	23	1	3	1	0	0	0	7	6	2	10	1
TOTAL TO DATE 19 92	9	705	22	32	1	18	21	12	1	9	9	6	21	102	4
TOTAL TO DATE 19 91	17	601	28	38	3	48	28	3	4	4	22	7	42	4	3
TOTAL TO DATE 19 90	16	272	27	34	1	20	15	1	2	1	12	12	10	12	7

OTHER DISEASES:

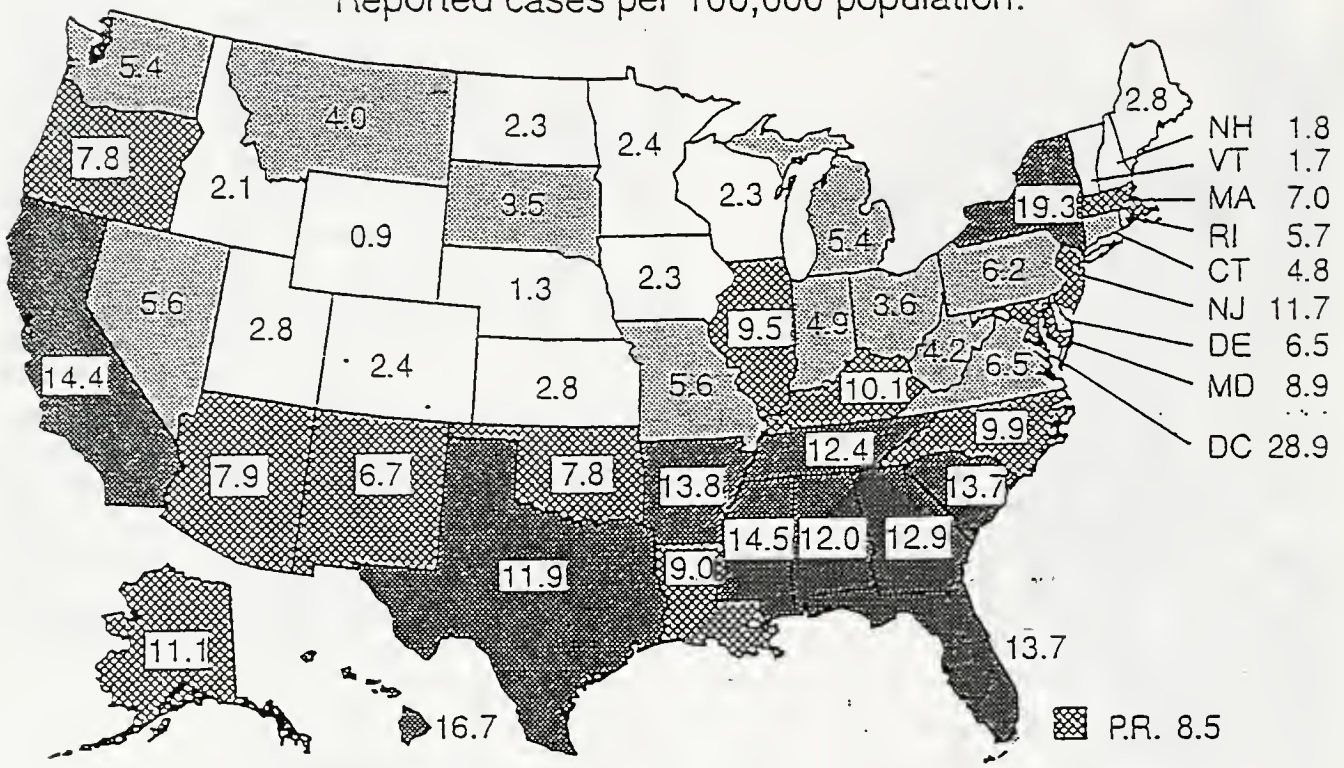
LEGIONELLOSIS: Fergus-1
Valley-1
Yellowstone-1

BAC. MEN. UNSPEC.: Yellowstone-1

COLORADO TICK FEVER: Missoula-1
CYTOMEG. VIR. ILL.: Fergus-1
KAWASAKI SYNDROME: Glacier-1

Tuberculosis
1988-1990

Reported cases per 100,000 population:



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VOL. 16 NO. 5 May 1992

Montana State Department of Health and Environmental Sciences

HAND, FOOT AND MOUTH DISEASE; MONTANA

The Montana Department of Health and Environmental Sciences has received numerous recent reports from health workers throughout the state of cases of hand, foot and mouth disease among young children. Following are answers to some frequently asked questions.

What is Hand, Foot and Mouth Disease? Hand, foot and mouth disease is an acute, self-limited, viral disease which often causes outbreaks among groups of children in nursery schools and daycare centers. Also called enteroviral vesicular stomatitis, the disease occurs worldwide, both sporadically and in epidemics with the greatest incidence in summer and early autumn. It usually occurs in children under 10 years of age. The disease is not to be confused with foot-and-mouth disease of livestock, which does not affect humans.

What causes this disease? Hand, foot and mouth disease is caused by a coxsackievirus, (the name is derived from the town of Coxsackie, in New York State, where this group of viruses were first isolated). This is an enterovirus which occurs typically in the gastrointestinal tract of man. Infections in man are usually subclinical.

How is the disease transmitted? The disease is spread by direct contact with nose and throat discharges, and in feces of infected persons (who may be asymptomatic), and by aerosol droplet spread. No reliable evidence of spread by insects, water, food or sewage. Cases are communicable during the acute stage of illness and perhaps longer, since these viruses persist in stool for several weeks.

What are the symptoms? The disease is characterized by sudden onset of fever, sore throat, and small (2-3 mm), diffuse, grayish vesicular lesions on the buccal surfaces of the cheek and gums and on the sides of the tongue, which gradually progress to slightly larger ulcers. Such lesions may persist for 7-10 days. A rash, especially on the palms, fingers and soles commonly accompanies infection.

How is the disease diagnosed? Diagnosis is usually based on characteristic clinical signs and symptoms. Stomatitis due to herpes simplex virus requires differentiation; it has larger, deeper, more painful ulcerative lesions, commonly located in the front of the mouth. Serologic diagnostic procedures are not available. Virus may be isolated from lesions and nasopharyngeal and stool specimens in tissue culture. Laboratory support of a diagnosis is available by calling the Montana Public Health Laboratories at 444-5255.

How is the disease treated? No specific therapy for enteroviral infections exists. Intravenous immune globulin with a high antibody titer the the infecting virus may be of benefit in immunocompromised patients and has been used in life-threatening neonatal infections.

Is the disease reportable? No. Hand, foot and mouth disease is not listed in ARM 16.28.202 as a reportable communicable disease. Your state epidemiologist, however, encourages health care providers to make known the number and location of cases which they identify. Physicians are asked to notify their local public health agency of cases.

INDEX

HAND, FOOT AND MOUTH DISEASE	1
INFLUENZA ACTIVITY, 1991-92	2
MONTANA AND HIV IN THE 90S	2
AIDS/STD BRIEFS	3
CDC VOICE INFORMATION SYSTEM	3
AVAILABILITY OF STREPTOMYCIN	3
TB AND DRUG TREATMENT CENTERS	4
MONTANA MORBIDITY	5

What control measures can be taken? Particular attention should be paid to personal hygiene, sanitary disposal of feces, cleanliness, and handwashing. Symptomatic children should be excluded from school and daycare settings. Enteric precautions are indicated for 7 days after onset of illness. Promote handwashing and other hygenic measures at home and school. Measures which reduce person to person contact decrease the potential for transmission. Investigation of contacts is of no practical value except to detect other cases in groups of preschool children.

INFLUENZA ACTIVITY, 1991-92 SEASON

The following report summarizes influenza activity in Montana and the United States from October 1991 through May 1992.

The first influenza virus isolates from Montana residents were identified during the week of November 24, 1991, by the Montana Public Health Laboratories. These isolates were identified as Influenza A/Shanghai (H3N2), and were from residents of Lewis and Clark County.

Through May 1992, the Montana Department of Health and Environmental Sciences received 106 laboratory-confirmed reports of influenza cases; 12% below the recent 5 year average. Of the 106 lab-confirmed cases identified, 103 (97%) were due type A, whereas 3 (3%) were due to type B.

Montana's influenza surveillance system relies primarily on the results of specimens submitted to the State's Public Health Laboratories. Beginning with the 1991-92 influenza season, school absenteeism monitoring was implemented as an additional component of influenza surveillance. Activity was widespread, but mild, throughout the seaseon. Cases occurred sporadically, or in small clusters.

Nationwide, influenza morbidity, during 1991-92, was characterized by early-season onset with peak activity in late December and early January, followed by a rapid decline. Influenza A activity early in the season was reported primarily in schools, but by early January had shifted to primarily to nursing homes. The predominant influenza strain was A(H3N2). Sporadic isolates of influenza B were reported during the season and represented less than 1% of the total isolates. Influenza activity had declined to off-season levels by early April.

MONTANA & HIV IN THE 90'S: SHARING THE CHALLENGE

The third semi-annual Montana AIDS conference was held at the Montana State University campus in Bozeman on May 27-29. The conference was co-sponsored by the Southern Montana AIDS Coalition, Northwest AIDS Education and Training Center, U.S. Centers for Disease Control, Montana Department of Health and Environmental Sciences, and Blue Cross Blue Shield. Over 300 health care professionals, social services providers, community based volunteers, persons living with HIV, and interested individuals attended the conference. There was truly something for everybody, with keynotes on current treatment for HIV disease, community outreach, physician/patient transmission, a model state level response, our own legislative history and future regarding HIV, fears and prejudice, as well as a panel on living with HIV in Montana.

A variety of strategies for education and prevention efforts were presented, including school based outreach and testing, peer education by teens, theater, traditional Native American techniques using ethnic social structures, rap music, and speakers' bureaus composed of persons with HIV disease. In addition, a quilt panel dedication ceremony was held during which five panels were introduced for inclusion in the Names Project Quilt, which will be displayed in its entirety in Washington D.C. this fall, and in part in Billings over Thanksgiving weekend.

High points were back to back sessions by Martin Delaney, Executive Director of **Project Inform** in San Francisco, and lay expert on the most current information on treatments and research. He offered detailed information, hope, honesty and encouragement for those infected with HIV and their caregivers.

Another high point was the panel, Coming Out and Coming Home to Montana, in which 7 courageous Montanans told their varied stories and experiences with HIV. Young and old, male and female, they gave a multi-faceted face to HIV in Montana.

As a result of this opportunity for people working with HIV/AIDS to come together, to gain new information, to share stories and strategies, and to support one another, it is hoped and fully expected that HIV prevention efforts in Montana will move to yet another level. For more specific information on any of the presentations, contact the Montana AIDS/STD Program at 444-3565.

MONTANA RESPONDS TO AIDS

Hotline 1-800-233-6668

AIDS/STD BRIEFS

- The Montana Public Health Laboratory reports that 255 of 4,053 samples (6.3%) collected for Chlamydia trachomatis screening were found to be positive for the months of April and May, 1992.

- There are two HIV Counseling Techniques Courses scheduled for the remainder of 1992. One will be held August 18-19 in Bozeman; the other in Kalispell, September 22-23. For more information or to pre-register, call Kim Hauge at the Montana AIDS Program, 444-3565

An Associated Press article on a study released by Harvard University researchers heralded a "grim new vision" of the AIDS epidemic worldwide, with numbers of those infected and with AIDS exceeding World Health Organization estimates. The study predicts that by the year 2000, 38 million to 110 million adults, and more than 10 million children, will be infected. The spread will be particularly explosive in Asia.

- If you are interested in receiving the MDHES monthly statistics of HIV/AIDS in Montana on a regular basis, please call Jim Murphy, 444-4744. Your name will be put on the mailing list. Otherwise you can receive those statistics quarterly in the Montana Morbidity Report or through a direct mailing.

CDC VOICE INFORMATION SYSTEM

The CDC Voice Information System is an automated telephone service that provides information about the MMWR and public health topics including AIDS, chronic fatigue syndrome, Lyme disease, rabies, hepatitis, influenza, international travel, and malaria. Information includes an overview of each topic; symptoms; prevention methods; immunization requirements, if any; and an option for transfer to a public health professional during business hours. The CDC Voice Information System is available 24 hours a day, 365 days a year; the telephone number is (404) 332-3555.

AVAILABILITY OF STREPTOMYCIN AND PARA-AMINOSALICYLIC ACID FROM CDC FOR TUBERCULOSIS THERAPY

Since the fall of 1991, streptomycin (SM) and para-aminosalicylic acid (PAS) have been unavailable for treatment of tuberculosis in the United States.

Beginning April 13, 1992, for an interim period, a limited supply of these drugs manufactured outside the United States will be available through the Centers for Disease Control under an investigational new drug agreement. These drugs initially will be made available only for patients with active tuberculosis that is resistant to both isoniazid and rifampin.

The Food and Drug Administration has identified U.S. companies that have agreed to manufacture SM and PAS. These drugs are expected to be commercially available later this year.

Clinicians interested in obtaining SM or PAS for their patients should contact the Montana Epidemiology Program Office at 444-3986.

-Reprinted, in part, from Centers for Disease Control Morbidity, and mortality Weekly Report, Vol. 41, No. 14, April 10, 1992.

TB: A RISING RISK FOR DRUG TREATMENT PATIENTS AND STAFF

Screening, prevention and control of infectious diseases is a particularly critical function in methadone treatment programs--both for the patients and for protecting the staff who work with these patients. Intravenous drug users are at high risk for a range of infectious diseases, such as syphilis and other sexually transmitted diseases, hepatitis, and the human immunodeficiency virus (HIV), which causes AIDS. Patients infected with HIV, because of their impaired immune systems, are particularly vulnerable to infectious diseases.

Experts at the Centers for Disease Control (CDC) are concerned about the rising U.S. incidence of tuberculosis (TB), particularly among those with HIV and strongly recommend that drug treatment programs regularly screen their staffs, as well as patients, for TB infection. The 30-year decline in U.S. cases ended in 1984 and the number of cases reported each year has now risen to almost 26,000. About 90 percent of the new TB cases occur in persons who have been infected in the past. Extremely effective drug regimens are available for treating patients who have the disease, as well as for preventing the disease in infected individuals (those currently without symptoms or clinical findings).

Federal regulations presently require that all patients in methadone programs receive a tuberculin skin test on entry and annual repeat tests for those who continue in the program. TB is commonly found in this population. Studies show that more than 20 percent of innercity black and Hispanic intravenous drug users in some areas have tuberculous infection.

Actions Methadone Programs Can Take

Methadone treatment programs are in a position to take significant additional measures, beyond screening, to protect their patients, staff, and the general public. These measures include:

- Work with public health authorities to arrange for quality laboratory services, essential for proper identification of the organism and for drug sensitivity testing;
- Explore the possibility of providing direct observed preventive therapy for patients with inactive tuberculous infection (this means that the anti-TB medication is swallowed in the presence of another person);
- Assure that all patients with chronic cough, fever, and other symptoms are rapidly evaluated for active TB and treated quickly.

Methadone programs can play a key role in delivering preventive care to vulnerable patients--intravenous drug users, those with HIV, the homeless--in ways that assure continuity of treatment and completion of the required chemotherapy regimen. Most infectious patients become non-infectious very rapidly--within a few days to weeks after starting chemotherapy and more than 95 percent of first-time patients can be treated successfully if they complete the prescribed regimen. Irregularity or interruption of self-medication cause most treatment failures. In some large urban centers, up to 60 percent of patients fail to complete the suggested duration of treatment. Experience suggests that the patient most likely to be noncompliant is the single, unemployed, innercity, male alcoholic.

Methadone programs can get assistance in setting up a screening and prevention program for TB and other infectious diseases from their local or State health departments. Staff will need training and information on issues particularly important for drug treatment patients, such as:

- Awareness of anergy--a condition affecting many patients who have HIV or take medications affecting the immune system -- in which patients do not show a significant positive reaction to the tuberculin skin test even though they have TB infection or active TB;
- Awareness of possible interactions between methadone and anti-TB medication (for example, patients receiving rifampin--a common TB medication--may need to have their methadone dosage increased to prevent withdrawal symptoms that can result from interaction of the two drugs;
- Awareness of the need for monthly checkups of persons on preventive therapy to check for toxicity (especially liver toxicity) resulting from the medication.

TB Educational Materials Available from CDC

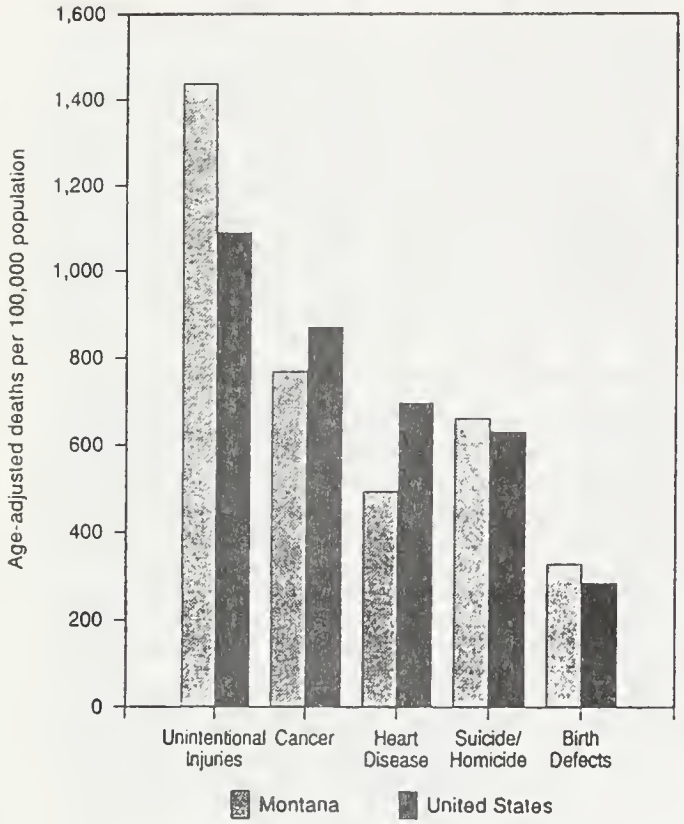
Educational materials for both patients and providers can be ordered free from the Centers for Disease Control. Materials on TB, which are available in multiple quantities, include fact sheets in English and Spanish, videotapes, booklets, slides, a wallchart and guides for caregivers. A "Tuberculosis Education Resource Guide" catalog and special materials for inmates of correctional institutions are also available. For information and an order sheet, contact:

Tuberculosis Educational Materials
Information Services, NCPS
Centers for Disease Control, Mailstop E-06
Atlanta, Georgia 30333

MAY 1992	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		4													
Big Horn		6	1	1											
Blaine	1	5													
Broadwater														1	
Carbon															
Carter															
Cascade	1	18		2				3			1			13	
Chouteau															
Custer		2						2							
Daniels															
Dawson															
Deer Lodge		2									3				
Fallon															
Fergus		1													
Flathead		6		1											
Gallatin		14	2												
Garfield														13	
Glacier		5				6									
Golden Valley															
Granite		1													
Hill		7					1	1							
Jefferson															
Judith Basin															
Lake	1	2									2	1	1		
Lewis & Clark		9	1						1						
Liberty															
Lincoln		1													
McCone															
Madison															
Meagher															
Mineral														5	
Missoula	2	13	4	1			1								
Musselshell			1												
Park		2													
Petroleum															
Phillips													1		
Pondera		1													
Powder River															
Powell															
Prairie															
Ravalli		3											1		
Richland															6
Roosevelt		8	1												
Rosebud							1							1	
Sanders															
Sheridan											1	1		1	
Silver Bow	1	5					1								
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone	1	40	1	4					1		1			8	33	0
MONTHLY TOTAL 1992	7	158	11	9	0	9	1	8	0	2	7	4	11	3	0
MONTHLY TOTAL 1991	10	179	5	0	0	5	0	1	0	1	10	4	7	15	0	0
MONTHLY TOTAL 1990	8	114	11	16	1	9	3	0	0	1	8	7	15	0	0
TOTAL TO DATE 1992	16	863	33	41	1	27	22	20	1	11	16	10	29	135	4
TOTAL TO DATE 1991	27	780	33	38	3	53	28	4	4	5	32	11	53	7	3
TOTAL TO DATE 1990	24	645	57	79	5	47	33	2	3	6	32	22	42	21	10

OTHER DISEASES:
E. coli 0157: Gallatin-1
PERTUSSIS: Missoula-1
MUMPS: Missoula-1
TULAREMIA: Bighorn-1
Broadwater-1
CHICKENPOX ENCEPH.: Gallatin-1
BAC. MEN. UNSPEC.: Lake-1
CYTOMEG. VIR. ILLNESS: Cascade-1
Yellowstone-1
COLORADO TICK FEVER: Park-1
REYE'S SYNDROME: Madison-1
LISTERIOSIS:
Wheatland-1

Leading Causes of Years of Potential Life Lost (YPLL) Before Age 65 Montana and United States



NOTICE OF PUBLIC HEARING FOR PROPOSED AMENDMENT OF RULE SETTING TUBERCULOSIS CONTROL REQUIREMENTS FOR EMPLOYEES OF SCHOOLS AND DAYCARE FACILITIES

On July 15, 1992, at 1:30 p.m., the Montana Department of Health and Environmental Sciences will hold a public hearing in Room C-209 of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the amendment of rule 16.28.1005 setting tuberculosis control requirements for employees of schools and day care facilities.

The proposed amendments would prohibit a school or day care facility from employing a person who fails to provide documentation of the results of a tuberculin skin test or other specified information to determine if s/he has communicable TB. Also, the rule change allows documentation other than annual X-rays to prove a tuberculin-positive employee is not communicable. Additionally, the rule would allow a school employee to transfer within a school district without having to repeat the TB test and provide documentation of their TB status.

The rule as, proposed to be amended, is available for review prior to the public hearing. To request a copy, call the Epidemiology Office at (406) 444-3986.

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